



### Simple Inquiry Form

Date of Contact (month/day/year) \_\_\_\_\_ County \_\_\_\_\_

Contact Location Method:

- In Person       Phone       U.S. Mail       E-Mail       Fax

Inquiry by:

- Beneficiary       Health Care Provider
- Family Member       Media
- Caregiver       Other (specify in notes)
- Program Partner/Subcontractor

Issue:

- Anonymous Complaint (referral made)       Program
- Anonymous Complaint (no action)       Volunteer Inquiry
- Billings/Claims/Coverage questions       Resource Request
- Presentation Request       Non-SMP info/referral
- General Consumer Protection       Other (specify in notes)

Program Involved:

- Original Medicare Part A (hospital)       Home Health Care
- Original Medicare Part B (outpatient)       Long term Care Facility
- Medicare Advantage       Medicare/Medicaid (general)
- Medicare Part D (Rx drugs)       Other Public Insurance
- Medicare Durable Medical Equipment (DME)       Consumer Protection
- Medicaid       Not Program Related
- Medigap       Other (specify in notes)
- Private Insurance

Was simple inquiry resolved/answered?  Yes  No      Time Spent: \_\_\_\_\_  
 Initial: \_\_\_\_\_

NOTES